EXHIBIT R

ADJUDICATOR: S. Cook

CLAIMANT NAME. ARTHUR JACKSON III
SSN: 203-42-8537

DAILY ACTIVITIES QUESTIONNAIRE

PLEASE COMPLETE THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. PLEASE EXPLAIN YOUR ANSWERS WHENEVER POSSIBLE BY GIVING DESCRIPTIONS AND EXAMPLES. COMPLETE THE QUESTIONS ACCORDING TO WHAT YOU DO **MOST** DAYS. YOUR COOPERATION IS APPRECIATED.

GENERAL INFORMATION:

1. Where do you currently live?
   Home_____ Apartment_____ Boarding House_____
   Nursing Home_____ Other X WITH FRIEND

2. Do you live alone? Yes_____ No X
   If no, who lives with you?
   CAMILLA MCFADDEN + HER TWO CHILDREN

SECTION I:

1. What do you do on a **TYPICAL** day from the time you wake up until going to bed?
   GET UP TAKE SHOWER AND GO DOWN STAIRS + WATCH TV EAT DINNER + GO TO BED

   How have these activities changed because of your condition?
   ? HAVE NOT CHANGED

2. Do you need any special help or reminders to take care of your personal needs (washing, bathing, shaving, dressing, etc.)?
   Yes X No_____
   If yes, **PLEASE DESCRIBE.**
   REMINDING ME TO CHANGE MY CLOTHES DAILY, AND BATHE

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3. Do you clean your home? NO
If yes, what type of things are done?
If no, what type of help is needed?
CAMILLA MCFADDEN DOES IT + KIDS HELP HER OUT AND THEY DO MOST OF THE WORK

4. Do you do your own shopping? NO
If yes, do you buy appropriate items and get correct change?
If no, what type of help is needed?
ONE OF MY NEIGHBORS DO IT FOR ME OR IT IS DELIVERED

5. Do you prepare meals?
If yes, what kinds of foods are made? YES
If no, what type of help is needed?
MICROWAVE

6. Do you drive a car? Yes X No X
Can you take a bus/train/cab alone? Yes_____ No X
If no, why?
CANNOT BE LEFT STANDING, LACK OF CONCENTRATION + GET LOST

7. Can you handle your own bills? Yes_____ No X
If no, why? MAJOR DEPRESSION SOMETIMES I JUST CAN'T DO IT.

SECTION II

1. Do you have any problems getting along with family, friends, neighbors, etc.? Yes X No_____
If yes, explain and **GIVE EXAMPLES.**
ANGER, CAN'T GET OUT OF BED SOMETIMES BECAUSE I DON'T WANT TO SEE ANYBODY.

2. Describe what kinds of activities you participate in with relatives, friends, etc.
NONE

How often do you participate in these activities?

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3. How well do you get along with people in authority (doctors, supervisors, police officers, etc.)? **PLEASE EXPLAIN.** AT TIMES I DO WELL BUT WHEN I AM NOT RESPONDING WELL TO MY MEDICATION THEN I HAVE PROBLEMS.

4. How well do you respond to criticism? **PLEASE EXPLAIN.** SAME, SOMTIMES OK. BUT I WILL LASH OUT.

5. Do you have any difficulty when you go out in public?
Yes X No_____
If yes, **PLEASE DESCRIBE.** I AVOID IT PANIC ATTACKS

6. Do you belong to any groups or clubs? Yes_____ No X
If yes, **PLEASE DESCRIBE.**

7. Have you ever been in fights, evicted, fired, etc.? Yes X No_____
If yes, **PLEASE DESCRIBE.**
ANGER, CONFUSION, RAGE, HATE + I HATE MYSELF HAVE NO DISCIPLINE FOR MYSELF

SECTION III

1. Do you have any hobbies or interests? Yes_____ No X
If yes, **PLEASE DESCRIBE.**

2. Are you able to start and complete projects or activities such as, reading a book, putting a puzzle together, sewing/needlepoint, fixing things around the house, etc.? Yes_____ No X
PLEASE DESCRIBE AND GIVE EXAMPLES.
I start but Forget where I was in the project or loose interest

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3. Are you able to plan each day such as, when to get up, start meals, finish household chores, go to appointments, etc.? Yes_____ No_X_
If no, **GIVE EXAMPLES.**
I CAN GET UP ON MY OWN, BUT NOW AFTER THIS DEPRESSION SOMEONE HAS TO PUT IT ON THE CALENDAR FOR ME.

4. Do you have trouble following instructions and carrying them out?
Yes_X_ No_____
If yes, **GIVE EXAMPLES.**
LACK OF CONCENTRATION, I START ONE THING THEN DO SOMETHING ELSE

SECTION IV

1. What happens when you are faced with changes such as, change in daily schedule, change in living arrangements, change in doctors etc.?
ANGER, I GET STRESSED THEN NOTHING HAPPENS BECAUSE I JUST LEAVE

2. What happens when you have a disagreement with someone?
DEPENDS ON HOW I AM RESPONDING TO MEDICATION COULD END UP IN FIGHT

3. Can you make decisions on your own? Yes_✓_ No_✓_
If no, who helps you make decisions?
MY FRIEND

4. Do you take medication for your condition? Yes_X_ No_____
Please list the medicine and amounts.
DESYREL 100 mg 1-2 AT BEDTIME
EFFEXOR 75 mg 2 x DAILY
KLONOPIN 1 mg. 2 x " 2 AT BEDTIME
PROCARDIA 30 mg 1 x "
PEPCID 20mg 1x
NAPROCIN
SEE BACK →

5. Do you need help taking medication? Yes_✓_ No_✓_
If yes, who helps you?
MY FRIEND
CANT REMEMBER IF ALL HAS BEEN TAKEN SO SHE CHECKS FOR ME

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SECTION V

IF YOU WORKED IN THE PAST, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

1. Did you usually report to work on time? Yes X No_____
   If no, **PLEASE DESCRIBE.**

2. Did you have good attendance? Yes X No_____
   If no, **PLEASE DESCRIBE.**

3. Were you usually able to keep up with your work? Yes X No_____
   If no, **PLEASE DESCRIBE.**

4. Were you able to concentrate on your work for extended periods of time? Yes X No_____
   If no, **PLEASE DESCRIBE.**

5. Did you have trouble getting along with your supervisors and/or coworkers? Yes_____ No X
   If yes, **PLEASE DESCRIBE.**

6. When changes were made at work that affected your job, were you able to accept these changes? Yes X No_____
   If no, **PLEASE DESCRIBE.**

7. **Additional Comments:**
   I JUST WANT TO BE ABLE TO STAY AT HOME + GET WELL AGAIN AND GO BACK TO WORK

9-22-96
Date

Signature of Person Completing Form

Relationship to Claimant

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PERSONAL PAIN QUESTIONNAIRE

1. Describe the location, severity, and nature (sharp, dull, aching, etc.) of your pain.
PAIN IS LOCATED IN ~~L-5, L-4, S-1~~ BACK AND GROIN.
ANY BENDING OR STANDING, SITTING
SHARP IN TESTICALS

2. What makes your pain worse (movement, cold weather, etc.)? Is your pain worse in the morning, afternoon, or evening?
PAIN IS ALL THE TIME NO MATTER WHAT

3. How often do you experience pain? Per day/per week? How long does the pain last?
PAIN IS ALL THE TIME NO MATTER WHAT

4. Is your pain located in a specific area or does it radiate (move) into other areas?
GOES FROM BACK (LUMBAR) TO GROIN AREA.
PAIN IN TESTICALS IS UNBEARABLE

5. Has your pain changed over the last 12 months? If so, how?
HAS NOT BEEN 12 MONTHS ~~SINCE~~

6. Are you using pain medication? Yes___ No X If yes, what is the name of the medication and the dosage? What is the name, address, and telephone number of the doctor who prescribed the medication?
NOTHING WORKS AND I AM AFRAID OF ADDICTION

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7. How does the medication affect the pain? What side effects from the medication do you have?

I AM NOT TAKING PAIN MEDICATION, IT DOES NOT WORK!!! STOP ASKING ME!!! PAIN!!!

8. Describe any other treatments that you use to relieve your pain (hot baths, therapy, exercise, etc.). How well do they work?

HAVE TRIED EPIDURAL BLOCKS, PHY. THERAPY HOT SHOWERS CANNOT BATHE, ICE PACKS

9. Did you ever attend a chronic pain program? Yes X No____
If yes, when and where?

FITZ MERCY HOSP - DR. KEVIN CAMPBELL
1500 LANSDOWNE AVE / PHY. THERAPY
DARBY, PA.

10. Describe the activities that you have had to restrict or stop because of pain.

MY WORKING ABILITIES, ALL RECREATIONAL
FAMILY CARE, HOUSE DUTIES, ETC.

11. Do you use an assistive device to walk (cane, crutch, etc.)? Yes____ No X
Are you able to walk without this device? Yes____ No____
When did you begin using this device?
What is the name, address and telephone number of the doctor who prescribed this device?

12. Has pain affected the amount of time you sleep? Yes X No____
If yes, please explain how your sleeping habits have changed.

NO SLEEP FOR DAYS AT TIME
SEE- (DESYREL 100 mg 1-2 AT BEDTIME)
PER DR. LEE SILVERMAN (FITZ MERCY HOSP PSHY. UNIT)

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13. Since your pain began, have your eating habits changed due to the pain? Yes X No___ Has your weight changed? Yes X No___ If yes, by how much?
50 LBS. DUE TO ECAVIL MEDICATION
If there has been a change in either direction, were you trying to change your weight? Yes___ No X

14. Has your ability to think and concentrate been affected by the pain? Yes X No___ If yes, please explain.
HAS MADE ME UNABLE TO WORK THUS GO INTO MAJOR DEPRESSION

15. Have you ever been referred to a psychologist/psychiatrist to help cope with pain? Yes X No___ If yes, please provide name, address, telephone number, and dates of treatment.
DR. LEE SILVERMAN, MD.
MEDICAL DIRECTOR INPATIENT PSYCHIATRY
1500 LANSDOWNE AVE
DARBY PA. 19023
610-237-4122, FAX 610-237-4695

ROSE MARINO, PH.D.
700 N. JACKSON ST.
MEDIA, PA 19063
610-566-4330
FAX - 610-566-5346

16. Are you able to take care of yourself as far as day-to-day needs are concerned? Yes X No X If no, please explain.
HAVE TO BE REMINDED OF CLOTHES CHANGES + SHOWERS AND APPOINTMENTS.

17. Please describe your activities for a typical 24 hour day. Please comment on things such as cooking, laundry, shopping, cleaning (vacuuming, dusting, scrubbing), reading, hobbies, car repairs, yard work, exercise, etc.
MICROWAVE COOKING - YES
NO SHOPPING, CLEANING, HOBBIES YARD WORK
CAN NOT STAY FOCUSED

Signature _____ Date 9-22-96

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EXHIBIT S

Neurology Associates, Ltd.
1514 Wolf Street
Philadelphia, Pa. 19145
(215)463-3029
(215)463-0131 Fax

Stephen E. Reznak, M.D.
Dan Gzesh, M.D.
Lorenzo G. Runk, M.D.
Debashis Biswas, M.D.

February 4, 2003

John Rollins, Esquire
1134 Rodman Street
Philadelphia, PA 19147

RE: Arthur Jackson, III

Dear Mr. Rollins:

As you know, I have been treating Mr. Jackson for a prolonged period time, including prior to his injuries of May 28, 2000.

He currently suffers from the neurological sequelae of a severe head injury. I believe the injury, a subdural hematoma, was related to the deprivation of clonazepam, which he had been receiving on a chronic basis, which led to a seizure and a subsequent head injury.

His neurological prognosis is poor at this time. It is likely that he has obtained maximum neurological improvement and further improvement is unlikely.

There is no therapy available for this condition at the current time.

Because of his injury, he has suffered significant cognitive and emotional impairment, including the inability to remember to perform activities of daily living, such as taking his insulin.

I believe the injuries are permanent, a direct result of the accident of May 28, 2000 and that he is incapable of self sufficient living.

All opinions are made with a reasonable degree of medical certainty.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Dan J. Gzesh, M.D.

DJG:MDP